

Abstract 0463 – Figure: Characteristics of the population

	1 st CB(n=106) N (%)	2 nd GB(n=106) N (%)	P
Age (years)	58±11	57±9	0.46
Gender (male)	64 (60%)	79 (75%)	0.03
AF history (years)	4.2±3	3.8±3	0.34
Enlarged LA	50 (47%)	54 (52%)	0.45
Complete PVI during the first procedure	97 (92%)	106 (100%)	
Phrenic nerve palsy	4 (4%)	5 (5%)	
Asymptomatic patients at 1 year	53 (50%)	81 (76%)	<0.01
Documented AF recurrence	47 (43%)	10 (9%)	<0.01
Redo procedure	41 (37%)	10 (9.4%)	<0.01

0029**Redo-ablations of atrial fibrillation: procedural characteristics depending on the choice of cryoenergy or radiofrequency ablation as the first line therapy**

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Introduction Pulmonary vein (PV) isolation has become a cornerstone therapy for symptomatic paroxysmal AF refractory to anti-arrhythmic drugs. Nowadays, the most common energies used to achieve PV isolation are cryoenergy and radiofrequency (RF). However, approximately one third of the patients have recurrences, mainly due to PV reconnections.

Little is known about the characteristics of the redo procedure, depending on the choice of the initial energy.

Methods Patients referred to our center for a RF redo ablation procedure of symptomatic paroxysmal AF (PxAF) between 2010 and 2014 were retrospectively enrolled.

Demographic data and characteristics of the initial ablation, i.e. cryoenergy or RF ablations, were collected. Number and location of PV gaps, and redo characteristics were reviewed.

Results 74 patients scheduled for a redo ablation of AF were included, 38 and 36 using RF or cryoablation for the first procedure, respectively. For the initial ablation, procedural and fluoroscopy times were significantly shorter when using cryoenergy (147.8±52.6 vs. 226.6±64.3 min, $p<0.001$, and 37.0±17.7 vs. 50.8±22.7 min, $p=0.005$, respectively). Overall, an identical

number of gaps were found during redo procedures of cryo and RF ablations. However, a significantly higher number of gaps were located in the right superior PV (RSPV) for patient first ablated with RF (0.9±1.0 vs. 0.5±0.9, $p=0.009$). The location of gaps was different, predominantly found in the anterior and superior parts of the left superior PV (LSPV), the anterior and inferior part of the left inferior PV (LIPV), the superior part of the right superior PV (RSPV), and in the postero-inferior part of the right inferior PV (RIPV) when using RF as the initial energy. For patient first ablated with cryoenergy, gaps were predominantly found in the anterior part of the left PV, evenly distributed in the RSPV, and in the postero-inferior part of the RIPV. Although not significant, redo procedures of cryoablations were slightly shorter and needed less RF duration times to achieve PV isolation (160.0±55.7 vs. 175.7±59.1 min, $p=NS$, and 954.1±796.7 vs. 1476.7±1269.6, $p=NS$).

Conclusion During redo procedures, gaps location pattern is different for patients first ablated with cryo or RF energy, and RSPV reconnections occur more frequently after RF ablation, probably due to poor contact in this region. Procedural characteristics of the redo ablation are similar.

Keywords atrial fibrillation; ablation; cryoablation; radiofrequency; redo

The author hereby declares no conflict of interest

0299**De novo atrial fibrillation in the acute coronary syndrome**

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Introduction De novo atrial fibrillation (AF) is common in the acute coronary syndrome (ACS), but most patients (P) are discharged in sinus rhythm (SR). The recurrence of arrhythmia in follow-up (FU) remains unknown and its undervaluation may have prognostic impact.

Aim To characterize a population with ACS and de novo AF and determine its prognostic impact.

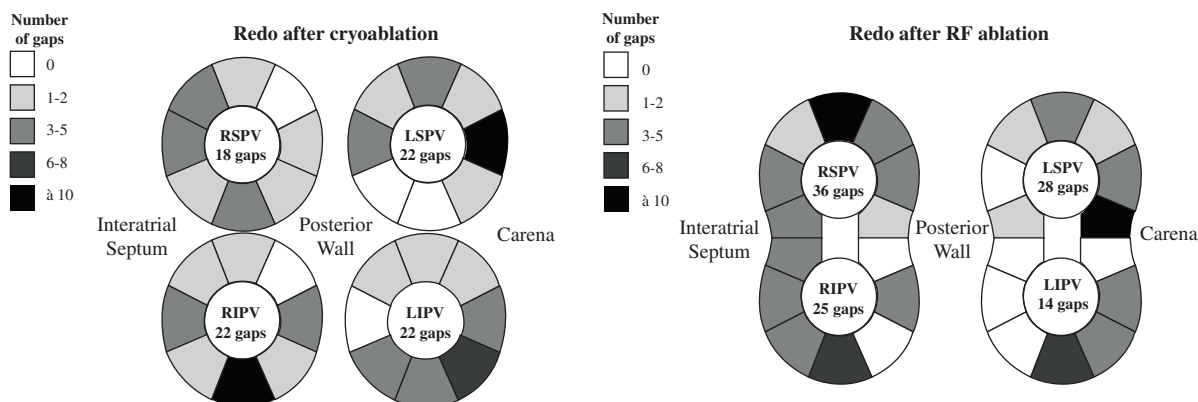
To evaluate the recurrence of AF and the incidence of ischemic stroke/systemic embolism in FU.

Methods We analyzed 2383 P consecutively admitted with ACS and with a minimum of 180 days FU.

De novo AF has been defined as AF first detected on admission or during hospitalization.

Results It has been observed de novo AF in 199 P (8.4%), the majority being male (70.4%). These patients were significantly older ($p<0.001$) and had higher HTA prevalence ($p<0.001$).

The echocardiographic evaluation showed a higher prevalence of mitral insufficiency ($p<0.001$) and left ventricular ejection fraction <40% ($p<0.001$). These P developed more frequently heart failure ($p<0.001$) and stroke ($p=0.001$) during hospitalization.

**Abstract 0029 – Figure: Localization of gaps, during the redo procedure**